



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-13-2474

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Received denials stating 'based on the findings of a review organization.' Our office does not have that documentation... these claims should be paid in full."

Amount in Dispute: \$1,695.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier is going to maintain their denial that Michael Lopez, DC is not owed the \$1,695.71."

Response Submitted by: AIG Dallas Worker's Compensation Service Center

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 9, 2012 through March 12, 2013	99213 and 99361	\$1,695.71	\$116.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Necessity Disputes.
4. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 216- Based on the findings of a review organization
 - 214 – Workers’ Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service treatment. Service Rendered does not relate to an accepted compensable injury or disease.
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 1 – This is bundled or non covered procedure based on Medicare guidelines; no separate payment allowed

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service January 9, 2012 through May 4, 2012?
2. Does the medical fee dispute referenced above contain information/documentation to support that dates of service October 11, 2012, January 4, 2013 and January 22, 2013 contain unresolved issues of medical necessity?
3. Does the medical fee dispute referenced above contain information/documentation to support that dates of service November 20, 2012, December 11, 2012 and March 12, 2013 contain unresolved issues of Extent-of-Injury?
4. Did the requestor bill in accordance with 28 Texas Administrative Code 134.203 for dates of service July 13, 2012 and October 5, 2012?
5. Did the requestor submit documentation to support the billing of CPT Code 99213 rendered February 6, 2013?
6. Is the requestor entitled to reimbursement for CPT Code 99213 rendered on February 6, 2013?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The dates of the services in dispute are January 9, 2012 through May 4, 2012. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 28, 2012. These dates of service are later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services, January 9, 2012 through May 4, 2012 do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file dates of service January 9, 2012 through May 4, 2012 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service January 9, 2012 through May 4, 2012.

The Division finds that the remaining disputed dates of service, July 13, 2012 through March 12, 2013 were filed timely and eligible for review by MFDR.

2. Review of the submitted documentation finds that dates of service October 11, 2012, January 4, 2013 and January 22, 2013 contains information/documentation to support that there are **unresolved** issues of medical necessity. The insurance carrier denied CPT Code 929213 with denial reason(s) code “216- Based on the findings of a review organization.”

The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under **Health Care Providers or their authorized representatives**.

28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The division finds that due to the unresolved medical necessity issues for CPT Code 99213 rendered on October 11, 2012, January 4, 2013 and January 22, 2013 are not eligible for review, until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

3. The requestor seeks resolution for CPT Code 99213 rendered on November 20, 2012, December 11, 2012 and March 12, 2013. Review of the submitted documentation finds that the medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute. The Division finds that the dispute contains unresolved issues of Extent-of-Injury. As a result, CPT Code 99213 rendered on November 20, 2012, December 11, 2012 and March 12, 2013 are not eligible for review by MFDR until final adjudication of the Extent-of-Injury issues.

The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of Extent-of-Injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent-of-injury issue are attached.

28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the Extent-of-Injury dispute

4. The requestor seeks reimbursement for CPT Code 99361 rendered on July 13, 2012 and October 5, 2012. The insurance carrier denied/reduced the disputed services with denial reason codes; "97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and "1 – This is bundled or non covered procedure based on Medicare guidelines; no separate payment allowed."

Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Review of the CMS-1500 documents that the requestor billed for CPT Code 99361-W1 on July 13, 2012 and October 5, 2012, no other CPT Code were billed on those dates, therefore no NCCI edits conflicts were identified. The Division finds that the insurance carrier denials are not supported. As a result, the disputed services are reviewed pursuant to the provisions of 28 Texas Administrative Code 134.204 (e) (4) (A).

28 Texas Administrative Code §134.204 states in pertinent part, "(e) Case Management Responsibilities by the Treating Doctor is as follows... (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added."

Review of the submitted documentation for the dates of service indicated above do not meet the documentation requirements outline in 28 Texas Administrative Code 134.204 (e) (4) (A). As a result, the requestor is not entitled to reimbursement for these services.

5. The requestor seeks reimbursement for CPT Code 99213 rendered on February 6, 2013. Review of the submitted documentation does not include copies of EOBs for the disputed charges. As a result, the disputed services are reviewed pursuant to the applicable rules and guidelines. Review of the SOAP note dated February 6, 2013 documents the billing of CPT Code Level 99213. As a result, the requestor is entitled to reimbursement for this service.

6. 28 Texas Administrative Code §134.203 states in pertinent part, “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...”

The recommended reimbursement amount for CPT Code 99213 rendered on February 6, 2013 is \$116.39, the requestor seeks \$116.01 therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$116.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$116.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	April 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.